



## EDEN SPA PATIENT INTAKE FORM

Please fill out and fax or email to your preferred location.

**Eden Spa Orlando**

2501 North Orange Avenue, Suite 186  
Orlando, FL 32804  
(407) 303-9727 | Fax (407) 303-0625  
FH.EdenSpaOrlando@FLHosp.org

**Eden Spa Altamonte**

601 East Altamonte Drive, Suite 1721  
Altamonte Springs, FL 32701  
(407) 303-3348 | Fax (407) 303-3335  
FH.Alt.Eden.Spa@FLHosp.org

Appointment Date \_\_\_\_\_  
Appointment Time \_\_\_\_\_

### Patient Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Birthdate \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ Patient Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired Retirement Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Student

### Guarantor Information

Primary Insurance Holder \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Holder's Phone Number \_\_\_\_\_

### Insurance

Primary Insurance \_\_\_\_\_ Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_ Provider Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_ Provider Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

### Prescription Information

Referring Physician \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Diagnosis \_\_\_\_\_ Items Needed \_\_\_\_\_

### Patient has script

Y or  N

Please bring prescription to your appointment.